







progressed to moderate hearing loss in the better ear. One child in the unilateral group progressed to a moderate bilateral hearing loss. The Median age of identification was 51.1 months for the mild bilateral group, 56.9 months for the high-frequency bilateral group and 60.4 months for the unilateral group. The authors reported that there was an average of 5 months between the first assessment appointment and confirmation of diagnosis. 91.4% of children received a recommendation for amplification – 54.1% within 3 months of confirmation of hearing loss and 37.3% after 3 months. No amplification recommendation was made for 22 children.

Patterns of recommendations for amplification differed for the bilateral and unilateral groups. 60.1% of children with mild bilateral hearing loss had an initial recommendation and only 26.1% of children with a unilateral loss. Change of recommendation occurred for 21 children, 9 of whom received a recommendation for discontinued use.

This study provides the most robust evidence for case management of this group. This study confirms the uncertainty reported in so many articles on whether to prescribe hearing aids and when. The largest limitation of this study was its retrospective design; past exposure information like duration and amount of use of amplification and other intervention services could not be gathered or reasons why these interventions were delayed or not used. Also, this study sought to report only on children with an acquired loss and although measures were taken to control for this, in some cases it will never be clear the age at which the onset of hearing loss occurred.

### ***Conclusion***

The criteria used by different authors to define the audiometric cut-off for inclusion for each configuration is not consistent across studies and therefore makes comparison of results difficult. However, there does appear to be great variation in the case management of children with minimal and mild bilateral hearing loss. A trend toward a longer gap between diagnosis and initiation of intervention in the form of amplification and communication development appears to be greater in this group than for children with more severe hearing losses. This gap deserves further investigation. Studies which explore reasons for delays (due to clinician uncertainty and/or parental uncertainty in how best to proceed) are needed. Reasons for the trends in different recommendations based on configuration of hearing loss seen in the Fitzpatrick, Durieux-Smith, and Whittingham study (2010) might be illuminated by such work.

To reduce the uncertainty when making recommendations for children with minimal and mild bilateral hearing loss, research on outcomes based on child characteristics and intervention types at different ages are needed. Ideally, these would be randomized control studies.

Also each of the groups included in the term “minimal hearing loss” may vary considerably and more research into specifics for each configuration is needed.

### ***Clinical Implications***

Clinicians should be aware that there is more often a delay between diagnosis and initiation of intervention for children with minimal and mild bilateral hearing loss. Early intervention has proven to provide the best outcomes for children with hearing loss and specifically children with mild bilateral hearing loss (Yoshinaga-Itano, et al. 2008). While there is still uncertainty regarding the best age at which to fit personal hearing aids and/or an FM system, early intervention may provide a benefit over a wait-and-

